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PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 6
Date 1-29-07
Bill No. SB 149

January 29, 2007

To: Senate Public Health, Welfare and Safety Committee

From: Dr. Gary Mihelish, President
National Alliance on Mental Illness of Montana

Re: Opposition to Senate Bill 149

As an advocate for individuals living with severe mental illness, it is very difficult for me to oppose Senate Bill 149. Everyone can agree there is a need to improve services for mentally ill individuals being held in the Department of Corrections. I just question if this is the best way to expend Montana's limited funding.

The State of Montana would benefit from this legislation: It would create 120 additional correction beds, reduce the stress on the Montana State Prison, possibly reduce the possibility of law suites by advocacy groups related to the care of the mentally ill in the Department of Corrections, reduce the census at the Montana State Hospital, improve the safety issues at the Montana State Hospital and probably reduce worker's compensation insurance at the Montana State Hospital.

I am concerned the bulk of the expenditures would benefit mentally ill inmates. What happens to the additional 300 to 400 mentally ill inmates in the Montana State Prison? The limited number of beds for STEP does not address the real problem adequately. Extensive oversight would be necessary to prove the outcomes of this program would justify the investment by the State of Montana.

Has anyone asked the question: What would happen if this amount of money were to be invested in the current correctional system to improve services and programs for all inmates suffering from severe mental illness? Monies dedicated to bricks. mortar and employees is money that could better spent developing appropriate treatment service for the mentally ill in existing facilities.

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Montana

Grade: F

Category Grades

Infrastructure	F
Information Access	D-
Services	F
Recovery Supports	F

Spending, Income, & Rankings

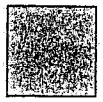
PC Spending/Rank	$123.41	11
PC Income	$24,610	45
Total MH Spending/Rank	$113 *(in millions)*	39
Suicide Rank		3

Recent Innovations

- Regional service area plan for Medicaid
- Multi-level approach to curb alcohol abuse that connects to core mental health problems, including the nation's third-highest suicide rate

Urgent Needs

- More beds in hospital and crisis units—not jails
- Crisis Intervention Teams (CIT) and jail diversion programs
- American Indian inclusion
- Better pay for providers



Montana is a profoundly beautiful state with a strong culture of self-reliance. It also is a vast and relatively poor state, a combination that leads to chronic shortages of healthcare providers, low pay, and a constant challenge to provide quality services. The state also has a significant Native American population, posing its own set of unique challenges to the mental healthcare system.

Montana is the only state in the country that has as many Assertive Community Treatment (ACT) teams as employees of the state mental health agency (5). It also can be credited for taking steps to address structural problems within the oftentimes complicated mental health system. It has a competent data collection system. Services have recently been aligned with Medicaid spending through three regional nonprofit agencies, taking into account local decision making. On the latter initiative, the jury is still out on how well it will work.

What is appalling is the lack of adequate psychiatric hospital beds in Helena, especially when one considers the lack of day treatment programs. Consumers report long hauls in shackles in the back of police cars taking them to the distant state hospital. The practice is not only an assault on individual dignity, but a burden on sheriffs, who are themselves victims of the system's inadequacies. Statewide, there is a need for more inpatient beds—the supply of which is shrinking.

Criminalization of mental illness is tied to capacity issues. If there are not beds in hospitals, it is easier to put people where there are beds—in jails and prisons. Jail diversion programs are needed in Montana. The absence of housing options, providers, and Crisis Intervention Teams (CITs) help fill homeless shelters as well.

PACT teams in Missoula, Bozeman, Billings, Great Falls, and Helena reflect a sensible deployment and a significant achievement. From the perspective of an overall system of care, however, without beds, the PACT are like an airplane trying to fly on only a wing and a prayer. Big Sky horizons need to be broader.

Alcohol abuse and co-occurring disorders have been a major problem for Montana, causing the state to consult national experts and develop a plan to address the problem. At a larger level, the Montana legislature has made efforts toward reducing its many highway deaths by outlawing open alcohol containers in vehicles. With alcohol and depression oftentimes underlying suicide,

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OP-ED CONTRIBUTOR

The Mentally Ill, Behind Bars

By BERNARD E. HARCOURT

Chicago

LAST August, a prison inmate in Jackson, Mich. — someone the authorities described as "floridly psychotic" — died in his segregation cell, naked, shackled to a concrete slab, lying in his own urine, scheduled for a mental health transfer that never happened. Last month in Florida, the head of the state's social services department resigned abruptly after having been fined $80,000 and is facing criminal contempt charges for failing to transfer severely mentally ill jail inmates to state hospitals.

Ten days ago, the Supreme Court agreed to determine when mentally ill death row inmates should be considered so deranged that their execution would be constitutionally impermissible. The case involves a 48-year-old Navy veteran who is a diagnosed schizophrenic. In the decade leading up to the crime he was hospitalized 14 times for severe mental illness.

According to a study released by the Justice Department in September, 56 percent of jail inmates in state prisons and 64 percent of inmates across the country reported mental health problems within the past year.

Though troubling, none of this should come as a surprise. Over the past 40 years, the United States dismantled a colossal mental health complex and rebuilt — bed by bed — an enormous prison. During the 20th century we exhibited a schizophrenic relationship to deviance.

After more than 50 years of stability, federal and state prison populations skyrocketed from under 200,000 persons in 1970 to more than 1.3 million in 2002. That year, our imprisonment rate rose above 600 inmates per 100,000 adults. With the inclusion of an additional 700,000 inmates in jail, we now incarcerate more than two million people — resulting in the highest incarceration number and rate in the world, five times that of Britain and 12 times that of Japan.

What few people realize, though, is that in the 1940s and '50s we institutionalized people at even higher rates — only it was in mental hospitals and asylums. Simply put, when the data on state and county mental hospitalization rates are combined with the data on prison rates for 1928 through 2000, the imprisonment revolution of the late 20th century barely reaches the level we experienced at mid-century. Our current culture of control is by no means new.

The graph on the left — based on statistics from the federal Census Bureau, Department of Health and Human Services and Bureau of Justice Statistics — shows the aggregate rate of institutionalization per 100,000 adults in the United States from 1928 to 2000, as well as the disaggregated trend lines for mental hospitalization on the one hand and state and federal prisons on the other.

The numbers include only state and county mental hospitals. There were many more kinds of mental institutions at mid-century, ones for "mental defectives and epileptics" and the mentally retarded, psychiatric wards in veterans hospitals, as well as "psychopathic" and private mental hospitals. If we include residents of those facilities, from 1935 to 1963 the United States consistently institutionalized at rates well above 700 per 100,000 adults — with highs of 778 in 1939 and 786 in 1955. It should be clear why there is such a large proportion of mentally ill persons in our prisons: individuals who used to be tracked for mental health treatment are now getting a one-way ticket to jail.

Of course, there are important demographic differences between the two populations. In 1937, women represented 48 percent of residents in state mental hospitals. In contrast, new prison admissions have consistently been 95 percent male. Also, the mental health patients from the 1930s to the 1960s were older and whiter than prison inmates of the 1990s.

But the graph poses a number of troubling questions: Why did we diagnose deviance in such radically different ways over the course of the 20th century? Do we need to be imprisoning at such high rates, or were we right, 50 years ago, to hospitalize instead? Why were so many women hospitalized? Why have they been replaced by young black men? Have both prisons and mental hospitals included large numbers of unnecessarily incarcerated individuals?

Whatever the answers, the pendulum has swung too far — possibly off its hinges.

It would be naïve, today, to address any of these questions without also considering the impact of imprisonment on crime. One of the most reliable studies estimates that the increased prison population over the 1990s accounted for about a third of the overall drop in crime that decade.

However, prisons are not the only institutions that seem to have this effect. In a recent study, I demonstrated that the rate of institutionalization — including mental hospitals — was a far better predictor of serious violent crime from 1926 to 2000 than just prison populations. The data reveal a robust negative relationship between overall institutionalization (prisons and asylums) and homicide. Preliminary findings based on state-level panel data confirm these results.

The effect on crime may not depend on whether the institution is a mental hospital or a prison. Even from a crime-fighting perspective, then, it is time to rethink our prison and mental health policies. A lot more work must be done before proposing answers to those troubling questions. But the first step is to realize that we have been wildly erratic in our approach to deviance, mental health and the prison.